Bureau of Quality Improvement Services
Residential Services and Supports Survey

Individual whose Services are being Surveyed: _____ Social Security Number_____/_____/_____

Date(s) of Survey: Start ____/____/_____ End ___/____/_____ Time Spent (hrs:min): _____

(Prepare data in the ISP and Behavioral Support Plan Review sections prior to arrival at residence)

Address of Home:_____

Setting: ☐ Waiver 24/7 staffing ☐ Waiver less than 24/7 staffing ☐ Waiver residing with family ☐ State Line Item Only ☐ Foster Care Adult/Child

Guardian's Name and Address: _____

Check type of Waiver (if any): ☐ None ☐ Autism Waiver ☐ DD Waiver ☐ Support Services Waiver

Date of most recent Plan of Care: _____ Attach copy

Providers listed on Plan of Care/ISP:

Provider Name	Provider Contact Information	Services Authorized on Plan of Care/ICLB	Confirmed with CM?
_____	_____	_____	YES NO
_____	_____	_____	YES NO
_____	_____	_____	YES NO
_____	_____	_____	YES NO
_____	_____	_____	YES NO

BDDS Service Coordinator: _____ District #_____

Review Incident Report Database: Have any incidents been reported for this individual in the past year? ☐ yes ☐ no If yes, attach copy of each.

Review complaint database: Have any complaints been reported for this individual in the past year? ☐ yes ☐ no If yes, attach copy of each.

Review Targeted Case Manager 90 day reviews for past 12 months. Attach copy of each. Note any problems:_____

Lead Quality Coordinator _____ Second Quality Monitor/Coordinator _____

(Lead Quality Coordinator is responsible for determining corrective action, assuring completion of data entry, filing of incident reports and follow up scheduling of this report)

Residential Services and Supports Survey

Upon arriving at the home, identify self as an Employee with the Bureau of Quality Improvement Services (provide ID card if requested) and state your purpose for visiting (i.e. to perform an annual provider survey for BQIS). The individual or legal representative has the right to refuse entry into the home.

Note any problems with being allowed into the home below, and notify supervisor before end of same business day. If no problems, enter "NA".

_____

_____

Names & Positions of staff present:

_____ (Name / position)	_____ (Name / position)	_____ (Name / position)
_____ (Name / position)	_____ (Name / position)	_____ (Name / position)

Is home staffing correct at time of survey? (circle one)
(Inquire if all staff scheduled are present)

YES NO

Communication with Individual

Communicate with the individual whenever possible. If the individual is non-communicative, indicate the person acting as their respondent by checking the appropriate selection:

Self □ Family Member □ Guardian □ Paid Caregiver □

Other □ (specify relationship to individual)_____

INDIVIDUALIZED SUPPORT PLAN REVIEW

1. ISP current? IAC 7-4-5(1)(2)	Yes No	Note any concerns:
2. Has facilitator completed training by an approved BDDS PCP training entity? IAC 7-4-1(c)	Yes No N/A	Note any concerns:
3. Personal and Demographic Information completed? IAC 7-5-2	Yes No N/A	Note any concerns:
4. Emergency Contacts section completed? IAC 7-4-1	Yes No N/A	Note any concerns:
5. Person Centered Planning Profile available and indicates person centered planning process used? IAC 7-4-1	Yes No N/A	Note any concerns:
6. Desired Outcomes individualized and based on person centered planning process? IAC 7-5-5	Yes No N/A	Note any concerns:
7. Proposed activities/strategies individually developed and tie into Desired Outcome? IAC 7-5-5	Yes No N/A	Note any concerns:
8. Responsible party identified for each proposed activity/strategy? . .. IAC 7-5-5(b)(5)	Yes No N/A	Note any concerns:
9. Time frame less than 12 months for each proposed activity/strategy? IAC 7-5-5(b)(6)	Yes No N/A	Note any concerns:
10. Statement of agreement signed and dated by individual/guardian? IAC 7-5-6	Yes No N/A	Note any concerns:
11. Support plan participants identified and provided copy of ISP? IAC 7-5-7 (a-d)	Yes No N/A	Note any concerns:

BEHAVIORAL SUPPORT PLAN REVIEW

Does individual have Behavioral Support services provider designated in ISP or have a Behavior Support plan? If NO, go to the "Individual Interview" section.			**YES NO**
If YES, review the following areas.			Confirmed by on-site suvey?
12. Does behavioral support plan define target behaviors? IAC 6-18-2 (b)	Yes No N/A	Note any concerns:	YES NO N/A
13. Is behavioral support plan based on functional analysis? IAC 6-18-2 (c)	Yes No N/A	Note any concerns:	YES NO N/A
14. Does behavioral support plan include written guidelines for teaching functional and useful replacement behaviors? IAC 6-18-2 (d)	Yes No N/A	Note any concerns:	YES NO N/A
15. Does behavioral support plan use nonaversive methods for teaching functional and useful replacement behaviors? IAC 6-18-2 (e)	Yes No N/A	Note any concerns:	YES NO N/A
16. Does behavioral support plan conform to ISP, including needs and outcomes identified in the ISP and ISP's specifications for behavioral support services? IAC 6-18-2 (f)	Yes No N/A	Note any concerns:	YES NO N/A
17. Does behavioral support plan include documentation system for direct care staff that includes all elements? IAC 6-18-2 (h)	Yes No N/A	Note any concerns:	YES NO N/A
18. Does behavioral support plan include assessing the use of medication and the appropriateness of a medication reduction plan or documentation that a reduction plan was implemented within the past 5 years and not effective? IAC 6-18-2 (i)	Yes No N/A	Note any concerns:	YES NO N/A
19. Documentation that behavior support plan is reviewed regularly by the support team? IAC 6-18-2 (j) (6)	Yes No N/A	Note any concerns:	YES NO N/A

BEHAVIORAL SUPPORT PLAN REVIEW (restrictive procedures)

Does Behavior Support Plan include any highly restrictive procedures? If NO, go to the "Individual Interview" section.			**YES NO**
If YES, does the plan contain the following:			Confirmed by on-site survey?
20. A functional analysis of targeted behavior for which highly restricted procedure is designed? IAC 6-18-2 (j) (1)	Yes No N/A	Note any concerns:	YES NO N/A
21. Documentation that risks of targeted behavior have been weighed against risks of highly restrictive procedure? IAC 6-18-2 (j) (2)	Yes No N/A	Note any concerns:	YES NO N/A
22. Documentation that systemic efforts to replace targeted behavior with an adaptive skill were used and were not effective? IAC 6-18-2 (j) (3)	Yes No N/A	Note any concerns:	YES NO N/A
23. Documentation that the individual, the support team, and the applicable human rights committee agree that the use of highly restrictive method is required to prevent significant harm to the individual or others? IAC 6-18-2 (j) (4)	Yes No N/A	Note any concerns:	YES NO N/A
24. Informed consent from the individual or legal representative? IAC 6-18-2 (j) (5)	Yes No N/A	Note any concerns:	YES NO N/A

INDIVIDUAL INTERVIEW SECTION

Individual Rights/Respect IAC 6-8-2, IAC 6-8-3, IAC 6-9-3

25. Do staff treat you with respect and ask you what you want when appropriate? (6-8-2), (6-8-3)	Yes No N/A	Note any concerns:
26. Are you given choices on activities, including when you would like to go places? (6-8-2), (6-8-3)	Yes No N/A	Note any concerns:
27. Do you have access to your personal possessions when staff is present? (6-8-2), (6-8-3)	Yes No N/A	Note any concerns:
28. Do you have enough privacy in your bedroom and bathroom when staff is present? (6-8-2), (6-8-3)	Yes No N/A	Note any concerns:
29. (ONLY TO BE ANSWERED BY INDIVIDUAL OR LEGAL REPRESENTATIVE) Are you satisfied with how your money is handled? Are financial issues being taken care of? Do you receive copies of the balanced checkbook monthly? (6-8-3)	Yes No N/A	Note any concerns:
30. This question is not to be asked in the presence of provider (ONLY TO BE ANSWERED BY INDIVIDUAL OR LEGAL REPRESENTATIVE) Are you satisfied with your providers? Do the people who help you treat you the way you want to be treated? (6-8-2), (6-8-3)	Yes No N/A	Note any concerns:
31. This question is not to be asked in presence of TCM: (ONLY TO BE ANSWERED BY INDIVIDUAL OR LEGAL REPRESENTATIVE) Are you satisfied with your case manager? Are all things being done the way you feel they should? (6-19-6)	Yes No N/A	Note any concerns:
32. "Do you know who your Targeted Case Manager is? What is their name?" (6-19-6)	Yes No N/A	If yes, name of TCM given by individual/respondent; otherwise enter "N/A"
33. "Has your Targeted Case Manager visited with you in the past 90 days?"(Can rephrase as "when did you last see your Targeted Case Manager?" Issue is - have they seen this person recently?) (6-19-6)	Yes No N/A	Confirm documentation of TCM presence in home and note. If documentation present, describe. If not present, note:

Individual Rights/Respect IAC 6-8-2, IAC 6-8-3, IAC 6-9-3

NOTE: For the safety items, if the individual is non-communicative, make a note to that effect and mark "N/A". (Caretaker will be questioned later in the survey regarding these safety issues.)		Was response satisfactory?
34. "What do you do if there is a fire?" (6-29-6)	Document response:	YES NO N/A
35. "What do you do if there is a tornado warning?" (6-29-6)	Document response:	YES NO N/A
36. "What do you do if you smell gas?" (6-29-6)	Document response:	YES NO N/A
37. "What plans or activities does the staff help you with?" (6-24-1 & 2)	List activities provided in response: •	Did reply match satisfactorily with ISP and records? If not, list differences / concerns: YES NO N/A

HEALTH CARE COORDINATION, by Provider

Is there a provider identified as responsible for Health Care Coordination in the ISP? **NOTE: IF INDIVIDUAL OR FAMILY MEMBER IS RESPONSIBLE FOR HCC, THEN GO TO "HEALTH CARE COORDINATION, Non-Provider" (6-25-1)**	**YES NO**	Who is responsible for HCC? ("Self", or name of family-member / provider)

38. "Do you have medical records or documentation pertaining to your medical treatment?" (6-17-3; 6-25-3)	YES – records are available NO – records unavailable N/A – no medical treatments	List all concerns:	
39. If YES, "May I look at them?" (6-17-3; 6-25-3)	YES – may see records NO – may not see records N/A – no records available	List all concerns:	
40. "Did you receive adequate, immediate treatment for any medical emergencies in the past year?" (6-25-3)	YES – had correct ER treatment NO – ER treatment NOT correct N/A – no medical emergencies	List all concerns:	
41. If YES, "Did you receive proper follow-up care?" (confirm by reviewing documentation) (6-25-3)	YES – had proper follow-up NO – did not receive needed follow-up N/A – no ER treatment	List all concerns:	
42. "Did you have a physical exam in the past year?" (6-25-2)	YES NO N/A	List all concerns:	
43. "Did you have a dental exam in the past year?" (6-25-2)	YES NO N/A	List all concerns:	
44. "Are all your medical conditions monitored and followed up as recommended or prescribed by your physician?" (6-25-3)	YES NO N/A	List all concerns:	
45. "Do you take medication?" (6-25-3 & 4)	YES NO N/A	List all concerns:	Agrees with ISP? Yes No N/A
46. If YES, "Do you give yourself the medication, or does someone else give it to you?" (6-25-3 & 4)	SELF – self-medicates OTHER – someone else administers N/A – no medication	List all concerns:	Agrees with ISP? Yes No N/A
47. If someone else administers medication, is there documentation for the date/time given with initials by the person who administered it, and is it problem free, i.e. no blank spaces, no errors etc? (review documentation) (6-25-4)	YES – documentation in order NO – problems with documentation N/A – self-administer or no meds	List all concerns:	
48. "What medications do you take?" (Does response match with information obtained from medication sheets?) (6-25-3 & 4)	YES NO N/A	LIST ALL MEDICATIONS:	

HEALTH CARE COORDINATION, by Provider (seizures)

Do you have a history of seizures? If NO, go to "Safety and Environmental" section.	YES NO	List any concerns:
49. Do you take medication to control your seizures? (6-25-3 & 4)	YES NO N/A	
50. Do you have a seizure disorder / epilepsy diagnosis? (6-25-3 & 4)	YES NO N/A	
Does seizure management system include the following elements? (6-25-7)		
51. Staff training on medication adminstration?	YES NO N/A	
52. Documentation of events immediately preceding, during, and following a siezure?	YES NO N/A	
53. Documentation of physician follow-up and follow along services?	YES NO N/A	
54. Individual's level of seizure medication checked annually or as ordered by physician?	YES NO N/A	
55. Information on seizures provided to all providers?	YES NO N/A	

HEALTH CARE COORDINATION, Non-Provider (Individual or Family-Member)

56. IF INDIVIDUAL/FAMILY MEMBER IS RESPONSIBLE FOR HEALTH CARE COORDINATION: Are you satisfied with how your health care needs are being met and feel that you receive sufficient support? If no, what concerns do you have and have you discussed these with your case manager?	YES NO N/A	Note response:

Residential Services and Supports Survey

Safety and Environmental Requirements

Request permission from individual before touring the residence. Best practice is the individual providing a tour of the home to assess the environment for health and safety issues.

Use these guidelines to review the interior and exterior of the home:

- Cleanliness of area related to risk of infection/disease
- Adequate heating and cooling
- Furnishings meet the needs of the individuals
- Minimal use of extension cords
- No frayed cords; empty light sockets, burned out or bare lightbulbs
- General maintenance – home is in good condition – holes patched, etc.
- Free from foul odors, insects and rodents;
- Cleaning and food items are stored properly
- Appliances and fixtures in working order
- No exposed wiring – including absence of outlet covers
- No window coverings that pose a danger to the individual (ex - cords from blinds that hang on the bed)

SAFETY & ENVIRONMENT, by Provider

Is there a provider designated as responsible for providing environmental and living arrangement support in the ISP? **NOTE: IF THIS IS THE INDIVIDUAL OR FAMILY MEMBER, GO TO THE "Safety & Environment, Non-Provider" section. (6-29-1)**	**YES NO**	Who is the responsible party? ("Self", or name of family-member / provider)
Review each of the following items		For any "NO" answers, describe specific issues and provide specific details as to why there is a cause for concern.
57. Is this home's interior and exterior free of any health and safety concerns (real risks for injury, infection, disease, etc.)? (6-29-2)	YES NO N/A	
58. Are all areas of the home accessible to the individual with unlimited access? (6-8-2)	YES NO N/A	
59. Are emergency numbers available for the police, fire and ambulance (911), the individual's legal representatives, the local BDDS office, the individual's case manager, adult protective services, and the DD waiver ombudsman in an area visible from the telephone used by individual or as indicated in ISP? (6-29-8)	YES NO N/A	

60. Is the food present congruent with the individual's diet needs as indicated in ISP? Ask permission before looking in cabinets. (i.e. –is there food appropriate for a diabetic diet if necessary, soft foods for a person without teeth, etc.) (6-26-1)	YES NO	
61. Are all medications stored separately, locked, and according to medication requirements (i.e. – refrigerated if necessary) and dispensed from the original container or as indicated in the ISP? (6-25-4)	YES NO	
62. Is all adaptive equipment as indicated in the ISP or other documentation available and meeting the needs of the individual? (glasses, hearing aids, communication devices, mobility aides, eating utensils, etc. – are they working properly and does the individual and/or staff know how to utilize them?) (6-32-2)	YES NO	
63. Is there a working smoke alarm (one that meets the individual's needs i.e. – visual alarm for individuals who are deaf, etc.) located in areas considered appropriate by local fire marshal. (6-29-4) NOTE: Test the alarm/s after asking permission to do so. Only the individual or family can deny permission.	YES NO	
64. Is there a fire extinguisher in the home that appears to be in working order and is checked annually? (6-29-4)	YES NO	
65. Is tap/bath water maximum temperature 110 degrees Fahrenheit or less if noted as a need in the ISP? (6-29-4)	YES NO	

SAFETY & ENVIRONMENT, Non-Provider (Individual or Family-Member)

66. If individual/family member is responsible for environmental and living arrangement supports, "Are all Health and Safety issues in the home being handled satisfactorily?"	YES NO N/A	Note any concerns:
67. "Are all of the environmental or living arrangement supports sufficiently provided for, and are all of your concerns are being met?"	YES NO N/A	Note response:

Review of Documentation - ISP

68. Is there a current ISP in the home (less than 12 months old)?	YES NO N/A	Date of Plan:
69. Is it identical to ISP reviewed before survey?	YES NO N/A	Date of Plan:

Check-off any areas that the Individualized Support Plan identifies a need for: (#70 – #86 below IAC 7-5-8)	If checked, does documentation confirm all supports in place?	If not checked, does documentation confirm that there is no need?	Describe all "NO" responses from 2nd or 3rd columns
70. ☐ Seizure management	YES NO N/A	YES NO N/A	
71. ☐ Allergies	YES NO N/A	YES NO N/A	
72. ☐ Uses or Requires Dentures	YES NO N/A	YES NO N/A	
73. ☐ Chewing difficulties	YES NO N/A	YES NO N/A	
74. ☐ Swallowing difficulties	YES NO N/A	YES NO N/A	
75. ☐ Dining difficulties	YES NO N/A	YES NO N/A	
76. ☐ Vision difficulties	YES NO N/A	YES NO N/A	
77. ☐ Hearing difficulties	YES NO N/A	YES NO N/A	
78. ☐ Speaking difficulties – mode of communication	YES NO N/A	YES NO N/A	
79. ☐ Behavior issues	YES NO N/A	YES NO N/A	
80. ☐ Issures discovered through incident reporting	YES NO N/A	YES NO N/A	
81. ☐ Medication/self-medication issues	YES NO N/A	YES NO N/A	
82. ☐ Lab testing	YES NO N/A	YES NO N/A	
83. ☐ Chronic conditions	YES NO N/A	YES NO N/A	
84. ☐ Water Temperature Safety	YES NO N/A	YES NO N/A	
85. ☐ Dentist	YES NO N/A	YES NO N/A	
86. ☐ Specialists	YES NO N/A	YES NO N/A	

Review of Documentation – POC, Assessment, etc.

Check-off any areas where other documents (POC, assessment, etc.) identify a need of: (6-17-3)	If checked, Documentation confirms all supports in place?	Describe any "NO" response in "Documentation confirms all supports in place?" column:
87. ☐ Health Care Coordination	YES NO N/A	
88. ☐ Specialist	YES NO N/A	
89. ☐ Adaptive equipment	YES NO N/A	

90. Does the individual's personal file contain, for the last 60 days, all documentation for: • Any medication administration • Any seizure management • Any health-related incident management • Any nutritional counseling • Any behavior support services • Goals from the ISP (6-17-3)	YES NO N/A	Note any concerns:
91. Is the documentation and environment free of any evidence that a reportable incident may not have been reported? (6-9-5)	YES NO N/A	**Incident report stating "<u>The following reportable items were seen during a BQIS Survey</u>" required for all "NO" answers.** Provide the details of the reportable incident both here and in Incident Report:
92. Is there documentation of ISP outcomes and progress made toward achieving those outcomes present? (6-17-3)	YES NO N/A	Note any concerns:

Residential Services and Supports Survey

Staff Interview Section

		Record specifics of staff response. "YES" marked only for competent, correct responses:	Note any concerns:
93. "Do you know what universal precautions are? Please tell me how you utilize them on the job". (i.e. – what steps do you take if you need to clean up blood)? (6-14-4)	YES NO N/A		
94. "Are you familiar with the signs and symptoms of seizure activity, including any aura prior to a seizure? What are they?" (6-14-4)	YES NO N/A		
95. "How would you document a seizure?" Ask specifically and view the documentation to assure that documentation includes activity before, during and after the seizure. (6-25-7)	YES NO N/A		
96. "Do you know the individual's diet needs, including how to prepare their food? Please tell me about the individual's diet needs." (6-14-4)	YES NO N/A		
97. "Do you know how to report an incident per the BDDS incident reporting procedure?" **(Includes knowing the types of reportable incidents and knowledge that they have the ability to independently report incidents to APS/CPS.)** (6-9-5)	YES NO N/A		
98. "Are you aware of possible side effects of the individual's medication? What are they?" NOTE: "N/A" only if not on medications (6-25-6)	YES NO N/A		
99. "Have you been trained in the individual's behavior management plan? What are the targeted behaviors and interventions used?" NOTE: "N/A" only if no behavior plan in the ISP (6-14-4; 6-18-2)	YES NO N/A		
100. "If manual restraints are used, have you had training in non-injurious aggression management techniques?" NOTE: "N/A" only if no manual restraints used and none in ISP. (6-18-2)	YES NO N/A		

Residential Services and Supports Survey

Staff Interview Section

NOTE: Response is not competent if the staff indicates they would phone for emergency assistance prior to leaving the home for fire or smelling gas. Staff should be able to state how to exit/take shelter, along with precautions to take and whom to contact.		Competent Response?
101. "What do you do if there is a fire?" (6-14-4)	Document response:	YES NO N/A
102. "What do you do if there is a tornado warning?" (6-14-4)	Document response:	YES NO N/A
103. "What do you do if you smell gas?" (6-14-4)	Document response:	YES NO N/A

Questions in this section are addressed to and should be answered by the BQIS staff person performing this survey:		
104. Is this visit and survey free of any observed or evidence of abuse, neglect or exploitation?	YES NO N/A	If "NO", file an incident report. Make decision on need to implement the BQIS IMINENT DANGER POLICY based on facts. Contact supervisor and provide update on filing of incident report, any other policy implementation, and get consensus on appropriate immediate action. Summarize findings and actions taken:
105. Is this visit and survey free of any observed heath or safety concerns for this individual not documented in the questions listed above that DO NOT meet the BDDS Incident Reporting criteria? (not serious enough to require an incident report or implementation of imminent danger policy)	YES NO N/A	If "NO", describe in detail:

Survey summary – Corrective Action plans vs. concerns needing attention

For each item in survey identified with a concern, indicate appropriate action needed by service provider in tables below

Survey items requiring follow-up by BQIS

Item #	Brief description of concern & recommended method of confirming compliance (ex. re-visit home; receipt of verification documents; etc)	provider

Survey items requiring informal attention by provider

Item #	Brief description of concern	provider

Surveyor signature

"I attest that this survey is an accurate account of findings based on my observations on the date and time indicated"

Lead Surveyor; _____ _____ _____

Signature Title Date Signed

For additional notes, attach sheets/documents as necessary